

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02170						02166					
1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO</u> c. LENGTH OF STAY IN TB <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO</u> <u>10-1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MOLLIE GRINDER ADAMS</u> First Middle Last						4. DATE OF DEATH <u>FEB 20 1967</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 27-1877</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME <u>JOHN W GRINDER</u>						14. MOTHER'S MAIDEN NAME <u>ELEANORA BAKER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN W ADAMS ELKTON VA</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart block & asystole</u> 4/201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic CVD & congestive myocardial failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old myocardial infarction in 1950</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>15 years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>2/20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>67</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>James E. Stoner Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/20/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR</u>						22d. ADDRESS <u>WALKERSVILLE, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MIT HOPE</u>		23d. LOCATION (City, town or county) <u>WOODSBORO</u>		(State) <u>MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Powell & Hutzler Woodboro Md</u>						25a. REC'D BY REGISTRAR <u>FEB 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

00110

STATE OF TEXAS



CERTIFICATE OF DEATH

02171

02167

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodsboro</u>			
c. LENGTH OF STAY IN 1b <u>12 days</u>				d. STREET ADDRESS <u>10-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CARL WILLIAM ANGLEBERGER</u>			4. DATE OF DEATH <u>Feb. 14, 1967</u>			5. SEX <u>M</u>	
6. COLOR OR RACE <u>W</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Dec. 20, 1896</u>	
9. AGE (In years last birthday) <u>70</u> yrs.			10. IF UNDER 1 YEAR Months Days			11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Charles J. Angleberger</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Belle Ketrrow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-36-7095</u>			
17. INFORMANT <u>Mrs. Virgie A. Angleberger, Woodsboro, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) } DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>67</u> , to <u>2/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>67</u> , and that death occurred at <u>1:00</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>James B. Thomas</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>James B. Thomas</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1915

STATE OF TEXAS

1915

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

02172

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02168

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY 'DR TDWN (If outside corporate limits, write RURAL and give nearest town) Rural-Knoxville, R.F.D. #1		c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Rural-Knoxville, R.F.D. #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) JOHN THOMAS ARNOLD		4. DATE OF DEATH Month 2 Day 27 Year 1967	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/15/1901
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months 2 Days 27 Hours 19 Min. 67	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew David Arnold		14. MOTHER'S MAIDEN NAME Amanda Catherine Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Andrew D. Arnold		Address Braddock Heights, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 286.5 Congestive heart failure DUE TO (b) Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) ROBERT J. THOMAS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 812 Tall House Ave. Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/3/67	
23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Middletown Maryland	
24. FUNERAL DIRECTOR Feete Funeral Home		ADDRESS Brunswick, Maryland	
25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

02150

1995

1941-1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
02173			CERTIFICATE OF DEATH		
02169					
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN TB Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Nursing Center			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 544 East Church Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) BARBARA A. R. BEST			4. DATE OF DEATH February 20, 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1882	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired homemaker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Frederick County, Maryland	
13. FATHER'S NAME John Henry Hamilton			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-10-9112		
17. INFORMANT Mr. Richard Best			Address Route # 5 Frederick, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident-recurrent 331X DUE TO (b) Arteriosclerotic vascular disease DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 65 , to Feb 20 , 19 67 , that (I) (we) last saw the deceased alive on Feb 20 , 19 67 , and that death occurred at 5:45 P.M. from causes and on the date stated above.					
22a. SIGNATURE LeRoy T. Davis			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-20-1967
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis			22d. ADDRESS 228 N. Market Street Frederick, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-23-1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland		
24. FUNERAL DIRECTOR Robert E. Bailey & Son			ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR FEB 24 1967
			25b. REGISTRAR'S SIGNATURE J. Charles Jones		

03163

03163

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10/10/1910		New York, N.Y.	
Cause of Death		Manner of Death		Date of Death		Place of Death		Physician's Signature	
Heart Disease		Natural		10/20/1955		New York, N.Y.		J. Smith, M.D.	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Cemetery		10/25/1955		10:00 AM		Cemetery		10/25/1955	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Cemetery		10/25/1955		10:00 AM		Cemetery		10/25/1955	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02174

02170

1. PLACE OF DEATH a. COUNTY: Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b Weeks				d. STREET ADDRESS 118 East Church Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First EDNA		Middle I.		Last BOPOST	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1899	
9. AGE (In years last birthday) 67 yrs.		10. AGE (In years last birthday) 67 yrs.		11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME George S. Clinton Bopst				14. MOTHER'S MAIDEN NAME Nettie Jane Sponseller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215 44 9725		17. INFORMANT Alvin M. Bopst, Jr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) calupic aortic stenosis (c) CNR				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 66 , to Feb , 19 67 , that (I) (we) last saw the deceased alive on Feb 2 , 19 67 , and that death occurred at 11:02 AM , from the causes and on the date stated above.							
22a. SIGNATURE A. Austin Pearre, Jr.				22b. DATE SIGNED 2/3/67		22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, Jr. M. D.	
22d. ADDRESS Toll House Avenue, Frederick, Maryland				22e. REC'D BY REGISTRAR FEB 7 1967			
22f. REGISTRAR'S SIGNATURE Charles Judge				22g. REGISTRAR'S NAME Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (city, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				25. REC'D BY REGISTRAR FEB 7 1967			
25a. REC'D BY REGISTRAR FEB 7 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			
25c. REGISTRAR'S NAME Charles Judge				25d. REGISTRAR'S ADDRESS Frederick, Maryland			

02130

02130

Carbide and
Calcium carbide
CNC

Chlorine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
02175					02171							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)							
a. COUNTY Frederick MARYLAND					e. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick							
c. LENGTH OF STAY IN 1b 22 years					d. STREET ADDRESS 29 South Court Street							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 29 South Court Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year			
Mary Ann Elizabeth Bowie Brown						Feb 17 1967						
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH			9. AGE (In years last birthday)			IF UNDER 1 YEAR IF UNDER 24 HRS.			
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept 9, 1897			69 yrs.			Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY *****			11. BIRTHPLACE (County & State, or foreign country) Frederick Co, Md			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Emory C. Bowie					14. MOTHER'S MAIDEN NAME Mary E. Thomas					Address Frederick, Md		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****					16. SOCIAL SECURITY NO. 220-30-8835					17. INFORMANT Mrs Evelyn Jackson 404 Carrollton Dr		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANOXIA 4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Pulmonary edema (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb 12, 1967 , to Feb 12, 1967 that (I) (we) last saw the deceased alive on Feb 16, 1967 , and that death occurred at 12:30 AM , from the causes and on the date stated above.												
22a. SIGNATURE Austin Pearre Jr.										22b. DATE SIGNED 2/17/67		
22c. PHYSICIAN'S NAME (Type) A. AUSTIN PEARRE JR.										22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-20-1967		23c. NAME OF CEMETERY OR CREMATORY Bartonsville			23d. LOCATION (City, town or county) (State) Frederick Co, Md				
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md						25a. REC'D BY REGISTRAR Feb 20 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

02112

OFFICE OF THE

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Fredrick

Maryland

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Fredrick

22 years

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22 South Court Street

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Elizabeth

Howie Brown

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Female Negro

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Sept 9, 1897

1897

Domestic

Domestic

Fredrick Co, Md

U.S.A.

Emory C. Davis

Mary E. Thomas

Fredrick, Md

280-30-9525 Mrs Evelyn Jackson 404 Carrollton Dr

280-30-9525 Mrs Evelyn Jackson 404 Carrollton Dr

AND CH

Handwritten signature/initials

Emilia

2-20-1897

Barrenville

Fredrick Co, Md

C. E. Hicks, III Fredrick, Md

FOR STATE
HEALTH DEPT.

02176

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02172

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Yellow Springs			c. LENGTH OF STAY IN IB Hrs		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Yellow Springs Road			d. STREET ADDRESS 300 Middle Street		
3. NAME OF DECEASED (Type or print) Maxton Wilson Butler			4. DATE OF DEATH Month February Day 28 Year 1967		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1935		9. AGE (In years lost birthday) yrs. 31
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Frederick, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Earl Biggus			14. MOTHER'S MAIDEN NAME Louise R. Butler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. 217-28-5938	17. INFORMANT Address Frederick, Md Louise B. Henry 23 W. Saints St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head 976X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Shot self in head			
20c. TIME OF INJURY Month, Day, Year 7:30 a.m. 2-28-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Yellow Springs - Frederick - Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert J. Thomas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-28-67	
EXAMINER'S NAME (Type) ROBERT J. THOMAS, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Frederick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-4-1967	23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City or Town) (County) (State) Frederick Fred. Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md			25a. REC'D BY REGISTRAR DATE MAR 2 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Frederick

Frederick

Frederick

Yellow Springs

Mr

Frederick

Yellow Springs Road

300 Middle Street

Frederick

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02177

CERTIFICATE OF DEATH

02173

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 10-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue Infirmary		d. STREET ADDRESS 9 East 'C' Street	
3. NAME OF DECEASED (Type or print) Louis Capino (Cochpenna)		4. DATE OF DEATH Month 2 Day 7 Year 1967	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH I/15/86
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Transfer		10b. KIND OF BUSINESS OR INDUSTRY Trucker (B&O R.R.)	
11. BIRTHPLACE (County & State, or foreign country) South Calbera, Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705/09/2660	
17. INFORMANT Charles Capino		Address Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Recurrent cerebral vascular accident DUE TO (b) Arteriosclerotic vascular disease DUE TO (c) 10 years.			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1967 to Feb 7, 1967 , that (I) (we) last saw the deceased alive on Feb 7, 1967 , and that death occurred at 3:45 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Le Roy T. Davis		22b. DATE SIGNED Feb 9, 1967	
22c. PHYSICIAN'S NAME (Type) LE ROY T. DAVIS M.D.		22d. ADDRESS FREDERICK M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/10/67	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick Md.
24. FUNERAL DIRECTOR Leete Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (see) please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

02178

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02174

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linekiln		10-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) MALSTER First MCKINLEY Middle Carter Last		4. DATE OF DEATH Month 2 Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1898
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
11. BIRTHPLACE (County & State, or foreign country) Brunswick, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME H. B. Carter		14. MOTHER'S MAIDEN NAME Lena Cannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. #1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry Edward Fisher, Jr. Hanover, Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous Hemorrhage DUE TO (b) Bronchogenic Carcinoma DUE TO (c) Stunting the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Chronic Bronchitis Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/12, 1967 to 2/12, 1967 that (I) (we) last saw the deceased alive on 2/12, 1967 , and that death occurred at 5:26 M, from causes and on the date stated above.			
22a. SIGNATURE C. DeLoach		22b. DATE SIGNED Feb. 12, 1967	
22c. PHYSICIAN'S NAME (Type) H. T. LOTT, M.D.		22d. ADDRESS Jefferson Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 16, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25. REC'D BY REGISTRAR DATE FEB 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

02179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02175

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS Route # 1, Adamstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Donald Ivan Creager			4. DATE OF DEATH Month February Day 11 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1916		9. AGE (In years last birthday) yrs. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY P & E. Company		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME (Unknown)			14. MOTHER'S MAIDEN NAME (Unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 178 16 1308		17. INFORMANT Mrs. Helen Creager (Same as item # 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Massive Bronchopneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert J. Thomas		M.D. DR. ROBERT J. THOMAS		22. DATE SIGNED 2-11-67	
EXAMINER'S NAME (Type) DR. ROBERT J. THOMAS		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	
				23d. LOCATION (City or Town) (County) (State) Point of Rocks, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS Fadeley		25a. REC'D BY REGISTRAR FEB 15 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02176

1. PLACE OF DEATH a. COUNTY Ft Detrick Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b 47 yrs				d. STREET ADDRESS 910 Shawnee Drive			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ward 200, Walter Reed General Hosp. Det.							
3. NAME OF DECEASED (Type or print) First CHARLES Middle DAVID Last CRIST				4. DATE OF DEATH Month Feb Day 26 Year 1967			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 May 1919	
9. AGE (in years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY US Govt		11. BIRTHPLACE (State or foreign country) Frederick, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Russell Crist			
14. MOTHER'S MAIDEN NAME Lulu Trout				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II			
16. SOCIAL SECURITY NO. 214-10-2914				17. INFORMANT Catherine Crist (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 13:20							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found in Gov't vehicle on Gov't property			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 26 Feb 19 67 p.m.				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ft Detrick, Md.	
20f. (City or town) Frederick				20g. (County) Frederick		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Clifford B. Lull, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) CLIFFORD B. LULL, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 26 Feb 67			
Address (Street, city, town, or county) Frederick, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
23d. LOCATION (City, town or county) Frederick, Maryland				(State) Md.			
24. FUNERAL DIRECTOR <i>R. E. Dailey</i>				ADDRESS 1201 N. Mt. St. Frederick, Md		25a. REC'D BY REGISTRAR 26 Feb 67	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				DATE FEB 28 1967			

02130

02130

Mr. Director, Washington, D.C.

Re: [illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,
[illegible]

Chief, [illegible]

Enclosure

Very truly yours,
[illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,
[illegible]

Found in [illegible] vehicle on [illegible] property

Very truly yours,
[illegible]

CLERK, [illegible]

Very truly yours,
[illegible]

50 Feb 67

1967

02181

CERTIFICATE OF DEATH

02177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN TB 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jefferson -- Rural d. STREET ADDRESS 101 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roger Lee Dade- Sr.			4. DATE OF DEATH Month Day Year February 14- 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9-1882	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days 1 7 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Maurice J. Dade				
14. MOTHER'S MAIDEN NAME Rachel Chiswell			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. 220-16-4782			17. INFORMANT Maurice L. Dade- Jefferson- Md. 21755				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Macmillan & Jamdise 157X DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma Pancreas (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Leukemia					INTERVAL BETWEEN ONSET AND DEATH 1 7 0 6 7 10		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 2/14 19 66 to 2/14 19 67 , that (I) (we) last saw the deceased alive on 2/14 19 67 , and that death occurred at 4:50p from the causes and on the date stated above.							
22a. SIGNATURE Dr. A. Talbot Brice			22b. DATE SIGNED Feb. 15-1967				
22c. PHYSICIAN'S NAME (Type) Dr. A. Talbot Brice			22d. ADDRESS Jefferson- Maryland 21755				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 16-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Md. 21701				
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son-			25a. REC'D BY REGISTRAR Feb 20 1967				
25b. REGISTRAR'S SIGNATURE Elwood T. Whitmore Frederick, Md. 21701			25c. REGISTRAR'S SIGNATURE Charles Judge				

08130

CERTIFICATE OF DEATH

08130

Blank certificate form with faint lines and text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

02182

CERTIFICATE OF DEATH

02178

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>Week</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		10-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>243 West Fifth Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Edward Davis</u>		4. DATE OF DEATH Month Day Year <u>February 9 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/1899</u>
9. AGE (In years lost birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick City</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MR. William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Grace Crum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 10 2779</u>	
17. INFORMANT <u>Mrs. Grace Davis (Same as item 2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Anoxia</u> DUE TO (c) <u>Calcific aortic stenosis and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>pulmonary insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pulmonary insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1125</u> , 19 <u>67</u> , to <u>219</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/9/67</u> 19 <u>67</u> , and that death occurred at <u>925A</u> AM, from causes on and on the date stated above.			
22a. SIGNATURE <u>A. Austin Pearce, Jr.</u>		22b. DATE SIGNED <u>2/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. Austin Pearce, Jr. M. D.</u>		22d. ADDRESS <u>Toll House Avenue, Frederick, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR <u>Etchison</u>		25a. REC'D BY REGISTRAR <u>M.R. Etchison & Son, Frederick, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		DATE <u>FEB 14 1967</u>	

05130

05130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02183

CERTIFICATE OF DEATH

02179

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adamstown, P.O.</u>			
c. LENGTH OF STAY IN 1b <u>2 WKS</u>				d. STREET ADDRESS <u>Adamstown -</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>JAY</u> Last <u>DAWSON</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1879</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-09-0984</u>		17. INFORMANT <u>Mrs INA Proctor - Rt 1 - Adamstown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC PYELONEPHRITIS</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>21</u> , 19 <u>67</u> to <u>2/20</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>2/20</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard C. Reynolds,</u>				22b. DATE SIGNED <u>2/20/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard C. Reynolds</u>	
22d. ADDRESS <u>804 Toll House Ave, Frederick, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town or county) (State) <u>Frederick Md</u>	
24. FUNERAL DIRECTOR <u>C.E. Hicks, 111 Frederick, Md</u>				25a. REC'D BY REGISTRAR <u>FEB 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02184

02180

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Smithsburg		c. LENGTH OF STAY IN lb 35 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Smithsburg		10-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1		d. STREET ADDRESS Route #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN ALVEY DRAPER		4. DATE OF DEATH Month Day Year February 13, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1896
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Saw-Mill	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hanson Clay Draper		14. MOTHER'S MAIDEN NAME Mary Jane Mellott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 213-18-8170	
17. INFORMANT Sterling Draper		Address 438 Liberty Street Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. Acute Alcoholism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.		22. DATE SIGNED 2/15/67	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Church Cem.		23d. LOCATION (City or Town) (County) (State) Frederick Co. Md.	
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Maryland		25a. REC'D BY REGISTRAR FEB 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03156

43150

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

02185

CERTIFICATE OF DEATH

02181

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN lb 50 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		d. STREET ADDRESS Water St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NINA H. EBY		4. DATE OF DEATH Month Feb. Day 10 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver Harbaugh		14. MOTHER'S MAIDEN NAME Catherine McClain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hugh Eby		Address Water St. Thurmont, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-Vascular-renal Syndrome DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 11 days 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1 - , 19 66 , to Feb. 10 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 10 , 19 67 , and that death occurred at 4 p.m. , from causes and on the date stated above.			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-13-67	
23c. NAME OF CEMETERY OR CREMATORY United Brethren Cem.		23d. LOCATION (City or Town) (County) (State) Thurmont Fred. Co. Md.	
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR DATE FEB 15 1967	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

18150

18150

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18150

1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02182

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Legore c. LENGTH OF STAY IN 1b 1 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If Institution, residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Legore d. STREET ADDRESS P.O. Box 243 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Michelle Tarmy Eckenrode				4. DATE OF DEATH Month Day Year February 8, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 19, 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ross Eckenrode				14. MOTHER'S MAIDEN NAME Hattie Mae Carbaugh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ross Eckenrode, Legore, Md. P.O. Box 243			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9210 Congestive Heart Failure - Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Asphyxia DUE TO (c) Aspirated Formula						INTERVAL BETWEEN ONSET AND DEATH	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Clifford B. Lull, Jr.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-8-67	
EXAMINER'S NAME (Type) Clifford B. Lull, Jr.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Fairfield Union Cemetery		23d. LOCATION (City, town or county) (State) Fairfield, Adams Co. Pa.	
24. FUNERAL DIRECTOR Clarence E. Wilson				ADDRESS Emmitsburg, Md.		25a. REC'D BY REGISTRAR FEB 14 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Jones			

03185

03185

03185

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02187

CERTIFICATE OF DEATH

02183

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 2 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		10-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Convalescent Center		d. STREET ADDRESS 21 Carroll St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DESSIE Middle J. Last ETZLER		4. DATE OF DEATH Month FEBRUARY Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1875
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Saxton		14. MOTHER'S MAIDEN NAME Josephine Routzahn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-46-5334	
17. INFORMANT Gertrude Etzler		Address Baltimore 21228 5808 Edmondson Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CHOLECYSTITIS 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) FRACTURE OF HIP (3/1/66)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/12, 1966 , to 2/7, 1969 , that (I) (we) last saw the deceased alive on 2/5, 1967 , and that death occurred at 9:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 2/7/67	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-10-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City or Town) (County) (State) Woodsboro Fred. Co. Md.	
24. FUNERAL DIRECTOR Raymond E. Croager		25a. REC'D BY REGISTRAR DATE FEB 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

28130

Also

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02188

CERTIFICATE OF DEATH

02184

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS 602 Wilson Place	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle Edward Last FACEY, Jr.		4. DATE OF DEATH Month FEBRUARY Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1897
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Coatesville, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert E. Facey, Sr.		14. MOTHER'S MAIDEN NAME Willie Mae Whiteside	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-07-4104	
17. INFORMANT Mrs. Susan A. Facey		Address 602 Wilson Pl. Fred. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSELEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 2/2 , 19 67 to 2/5 , 19 67 , that (1) (we) last saw the deceased alive on 2/5 , 19 67 and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 2/5/67	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds		22d. ADDRESS 804 Toll House Avenue Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland	
25a. REC'D BY REGISTRAR FEB 9 1967		25b. REGISTRAR'S SIGNATURE Judge	

82 LSC

28130

Abstract

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February 2 1903

2. *Staphylococcus aureus*

(1997-1998)

9-298

Robert E. Brown

4

2/2

50

315

2/2/20

0-5

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
02189			CERTIFICATE OF DEATH		
02185					
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS Linganore Road Route #6		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HILDA Middle E. Last LANGER FISHER			4. DATE OF DEATH Month February Day 17 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 4, 1900		9. AGE (In years last birthday) yrs. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Allegheny County, Penn.	
13. FATHER'S NAME Herman Langer			14. MOTHER'S MAIDEN NAME Margaret Hack		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 276-09-9017		17. INFORMANT Mr. J. Stanley Fisher Rt. # 6 Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 2/16 , 19 67 to 2/17 , 19 67 , that (I) (we) last saw the deceased alive on 2/16 , 19 67 , and that death occurred at 5:30 A. M, from causes and on the date stated above.					
22a. SIGNATURE James B. Thomas		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-17-1967		
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas		M.D.	22d. ADDRESS 228 N. Market Street Frederick, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Montour Cemetery	23d. LOCATION (City or Town) (County) (State) Oakdale, Pennsylvania		
24. FUNERAL DIRECTOR Robert E. Dailey & Son			ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR DATE FEB 20 1967
					25b. REGISTRAR'S SIGNATURE J. Charles Judge

03182

CERTIFICATE OF DEATH

03183

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1910		New York, N.Y.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Burial Place	
1955		10:00 AM		Home		Dr. Smith		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witnesses		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02190

CERTIFICATE OF DEATH

02186

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODS BORO			
c. LENGTH OF STAY IN 1b 2 DAYS				d. STREET ADDRESS 10-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALLEN LYCURGUS FLANIGAN				4. DATE OF DEATH Month Day Year FEB 16 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 28 - 1898	
9. AGE (in years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILWAY SHOP				10b. KIND OF BUSINESS OR INDUSTRY PAINTING			
13. FATHER'S NAME LYCURGUS FLANIGAN				14. MOTHER'S MAIDEN NAME FLORENCE POWELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 219-12-1262			
17. INFORMANT Address RURAL				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure & Shock 5411 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) Generalized Peritonitis DUE TO (c) Cystic Duodenal Peptic Ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephrosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1, 1957 to Feb. 16, 1967 , that (I) (we) last saw the deceased alive on Feb. 16, 1967 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE E. A. DeTibarn				22b. DATE SIGNED 2/18/67			
22c. PHYSICIAN'S NAME (Type) E. A. DETIBARN				22d. ADDRESS Wallerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/20/67		23c. NAME OF CEMETERY OR CREMATORY MT HOPE		23d. LOCATION (City, town or county) (State) WOODS BORO MD	
24. FUNERAL DIRECTOR Powell & Hartzler				25a. REC'D BY REGISTRAR Wallerstown, Md.			
25b. REGISTRAR'S SIGNATURE Wallerstown, Md.				DATE FEB 21 1967			

08180

08180

1028

2, A-D-T-28-2

02191

CERTIFICATE OF DEATH

02187

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>28 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fredrick Memorial Hosp.</u>		d. STREET ADDRESS <u>Poolesville - Reince</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES GRUNDY FOWLER</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19-1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitation Montg Co Md.</u>		9. AGE (In years lost birthday): <u>59</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Robert H Fowler</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>235-09-1237</u>		17. INFORMANT <u>Mrs Venious Fowler - Poolesville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS OF MIDDLE CEREBRAL ARTERY</u> 332X DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1/26</u> , 19 <u>67</u> , to <u>2/24</u> , 19 <u>67</u> that (1) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>67</u> , and that death occurred at <u>10:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Richard C. Reynolds</u>		22b. DATE SIGNED <u>2/24/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	23d. LOCATION (City or town) (County) (State) <u>Beekville Montg. Md</u>
24. FUNERAL DIRECTOR <u>William B. Hilton, Barnesville, Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

78150

STANDARD 10

78150

02192

CERTIFICATE OF DEATH

02188

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Knoxville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 10-1	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Giles		4. DATE OF DEATH Month Feb Day 20 Year 1967	
5. SEX F.	6. COLOR OR RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/9/1900
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Henry Giles	
14. MOTHER'S MAIDEN NAME Nellie Nightengale		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT John Giles Address Knoxville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANOXIA DUE TO Plural effusion (b) carcinoma of breast with metastasis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 67 to 2/20/67 , 19 67 , that (I) (we) last saw the deceased alive on 2/20/67 , and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE A. Austin Pearre, Jr. M.D.		22b. DATE SIGNED 2/21/67	
22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, Jr. M.D.		22d. ADDRESS Frederick Md.	
23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF 2/24/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Road Cemetery	23d. LOCATION (City or Town) (County) (State) Knoxville Md.
24. FUNERAL DIRECTOR Fete Funeral Home		25a. REC'D BY REGISTRAR Brunswick Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

82150

2130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02193

CERTIFICATE OF DEATH

02189

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ladiesburg		c. LENGTH OF STAY IN 1b 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rural Ladiesburg	
3. NAME OF DECEASED (Type or print) First Middle Last Ethel Anna Glacken		4. DATE OF DEATH Month Day Year February 18, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1915
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 4 mos.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Glacken		14. MOTHER'S MAIDEN NAME Mary Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-24-8790	
17. INFORMANT Mr. Jesse T. Glacken, Ladiesburg, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Osteoarthritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/8 , 19 57 , to 2/18 , 19 67 , that (I) (we) last saw the deceased alive on 2/3 , 19 67 , and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE R. A. McVaugh		22b. DATE SIGNED 2/20/67	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		22d. ADDRESS Taneytown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fairfield Cemetery		23d. LOCATION (City or Town) (County) (State) Fairfield, Adams Co., Penna.	
24. FUNERAL DIRECTOR John H. Skiles C. O. Fuss & Son (John H. Skiles) Maryland		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE FEB 23 1967	

02194

CERTIFICATE OF DEATH

02190

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Co. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES E. GRIMES		4. DATE OF DEATH Month Feb. Day 26 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-1885
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Grimes		14. MOTHER'S MAIDEN NAME Rachael Warfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-36-0373	
17. INFORMANT Mrs. Esther Warner		Address Thurmont, Md. RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Arteriosclerotic vascular disease DUE TO (c) 3 years			INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1964 to Feb. 26, 1967 , that (I) (we) last saw the deceased alive on Feb. 26, 1967 , and that death occurred at 8:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE LeRoy T. Davis		22b. DATE SIGNED 2/28/67	
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis		22d. ADDRESS Professional Bldg. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Emmitsburg Fred. Co. Md	
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR DATE MAR 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05120

CERTIFICATE OF DEATH

05120

Name of Deceased		Date of Birth		Sex	
John Doe		1925-01-01		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		1980-01-01		Heart Disease	
Occupation		Residence		Manner of Death	
Teacher		123 Main St		Natural	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		Hospital	
1980-01-01		New York City		St. John's Hospital	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02195					02191						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)						
a. COUNTY		Frederick			a. STATE		b. COUNTY				
		MARYLAND			Maryland		Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
RURAL Walkersville			7 years		RURAL Walkersville						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First		Middle		Last		Month		Day Year			
CALEMEDIA		ELLEN		GROSSNICKLE		February 28		1967			
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)			
Female		White		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		December 22, 1878		88 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Housewife			Own Home		Frederick Co. Maryland.			USA.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Levi Brandenburg					Louise Grossnickle						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.						
No *****					Mrs. Cyrus Schroyer, Walkersville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)											
4201 DUE TO Coronary insufficiency											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Arteriosclerotic cardiovascular disease											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m.		Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
19											
21. I certify that (I) (this hospital) attended the deceased from August 1960, to Feb. 28, 1967, that (I) (we) last saw the deceased alive on Feb. 3, 1967, and that death occurred at 8:10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS	
Ernest A. DeTTBARN					2/28/67		ERNEST A. DETTBARN			Walkersville, Maryland	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS		22e. REC'D BY REGISTRAR			22f. REGISTRAR'S SIGNATURE	
Burial					3/4/67		Grossnickle Church of the Brethren Cemetery			Ellerton, Fred. Co. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial					3/4/67		Grossnickle Church of the Brethren Cemetery		Ellerton, Fred. Co. Md.		
24. FUNERAL DIRECTOR'S SIGNATURE					24a. ADDRESS		24b. REC'D BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		
Gladhill Company, Middletown, Maryland.					DATE		MAR 3 1967		J. Charles Judge		

1915

CERTIFICATE OF DEATH

1915

THE STATE OF TEXAS, COUNTY OF DALLAS, BEFORE ME, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 1915.

Notary Public in and for the State of Texas.

MAR 3 1915

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02196

CERTIFICATE OF DEATH

02102

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		10-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 334 East Third Street				d. STREET ADDRESS 334 East Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE E. B. GROVE				4. DATE OF DEATH Month February Day 12 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1906	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ox Fiber Brush Co.				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Emory Thurston Grove				14. MOTHER'S MAIDEN NAME Daisey E. Babel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-10-1906		17. INFORMANT Mrs. Sarah Grove 334 E. Third St. Fred. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/9, 1966 , to 2/12, 1967 , that (I) (we) last saw the deceased alive on 2/12, 1967 , and that death occurred at 1:30 P.M. from causes and on the date stated above							
22a. SIGNATURE James B. Thomas				22b. DATE SIGNED 2-12-1967			
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas				22d. ADDRESS 228 N. Market Street Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-15-1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son				25a. REC'D BY REGISTRAR Frederick, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

52150

02150

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02197

CERTIFICATE OF DEATH

02193

Item #1 Film #G385 2/20/67 pc

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>-</u> Last <u>HACKLEY</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? 1920</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u> </u>		14. MOTHER'S MAIDEN NAME <u>Cassie Hackley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>135-26-6997</u>	
17. INFORMANT <u>Howard Hackley</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY CONGESTION</u> DUE TO (c) <u>ASPIRATION OF VOMITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTESTINAL HEMORRHAGE, SITE UNDETERMINED - CHRONIC ALCOHOLISM</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 25</u> , 19 <u>67</u> to <u>FEB 5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>FEB 5</u> , 19 <u>67</u> , and that death occurred at <u>8:25 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>G.F. McAdams</u>		22b. DATE SIGNED <u>2/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.F. McADAMS, MD</u>		22d. ADDRESS <u>810 TOLL HOUSE AVE, FREDERICK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-9-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORRIS</u>		23d. LOCATION (City, town or county) (State) <u>Hume, VA.</u>	
24. FUNERAL DIRECTOR <u>Royston Funeral Home, Marshall, Va.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

02130

02130

RICHARD

HADLEY

ACUTE CARDIAC FAILURE

RESPIRATORY DISTRESS

RESPIRATORY DEPRESSION

INVESTIGATE MEDICAL HISTORY AND PHYSICAL EXAMINATION

10/10/50

10/10/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02198					02194				
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 21701			c. LENGTH OF STAY IN 1b Since Nov. 63		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rural RD#4				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Monocacy Hall Nursing Home					d. STREET ADDRESS Feagaville			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last IDA LAURA CATHERINE HIMES					4. DATE OF DEATH Month Day Year February 15, 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Aug 1870		9. AGE (In years last birthday) 96 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Feagaville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frederick David Heffner					14. MOTHER'S MAIDEN NAME Julia Ann Eyler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 215 26 0961		17. INFORMANT Mrs. Virgie C. Young (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i> <i>many years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>Feb. 15</i> , 1967, that (I) (we) last saw the deceased alive on <i>Jan. 28</i> , 1967, and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>E. A. Dettbarn</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 16 Feb 1967		
22c. PHYSICIAN'S NAME (Type) E. A. Dettbarn, M. D.					22d. ADDRESS Walkersville, Maryland 21793				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery			23d. LOCATION (City, town or county) (State) Nr. Feagaville, Md.		
24. FUNERAL DIRECTOR <i>Frank R. Smith Jr.</i> M. R. Etchison & Son, Frederick, Md. 21701					25a. REC'D BY REGISTRAR DATE FEB 21 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02199					02195				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Frederick</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick, Md.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Doubs</u>				
c. LENGTH OF STAY IN 1b <u>2 months</u>					d. STREET ADDRESS <u>Box 35</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Lisa</u> Middle <u>Myers</u> Last <u>Holland</u>					4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negroid</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-66</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>25</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Clark E. Myers</u>					14. MOTHER'S MAIDEN NAME <u>Rachel Holland</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CLARK Myers</u> Address <u>Bx 35-Doubs, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia & Pneumonia</u> 0534 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 13</u> , 19 <u>67</u> , to <u>Feb 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 19 <u>67</u> , and that death occurred at <u>5:20</u> PM, from the causes and on the date stated above.									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE <u>J.F. Baker</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>J. Fred Baker</u>					22d. ADDRESS <u>Fred Medical Center, Fred, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town or county) (State) <u>Frederick Md</u>		
24. FUNERAL DIRECTOR <u>C.E. Hicks, 111 Frederick, Md</u>					25a. REC'D BY REGISTRAR <u>FEB 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

02183

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Grand Medical Center, Fred, Md

Frederick Baker

78

Frederick

Frederick

8-14-87

Frederick

C. E. Hicks, III, Frederick, Md

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02196

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 14 John Hanson Apt.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER		First Middle Last B. JACKSON		4. DATE OF DEATH Month February Day 6 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 18, 1898	9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Ox-Fibre Brush Co.		11. BIRTHPLACE (State or foreign country) Spur, Texas			
13. FATHER'S NAME (Unknown)				14. MOTHER'S MAIDEN NAME (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220 09 8041		17. INFORMANT Ernest Jackson, R.F.D. #1		Address R. Frederick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4201 DUE TO (b) Coronary Artery Occlusion DUE TO (c) Arterio-Sclerotic Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert J. Thomas		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) February 6, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE FEB 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

05102

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02197

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick		c. LENGTH OF STAY IN 1b minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Frederick Memorial Hospital		d. STREET ADDRESS 5929 LeMay Rd.	
3. NAME OF DECEASED (Type or print) ROBERT First Middle Last Rexey JONES		4. DATE OF DEATH Month Day Year February 5, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1936
10a. USUAL OCCUPATION (Give kind of work done during life, or if retired) Electronics		10b. KIND OF BUSINESS OR None	9. AGE (In years birthday) yrs. 30 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Manassas, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H. R. Jones		14. MOTHER'S MAIDEN NAME Princess Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 226-42-3376	
17. INFORMANT Mrs. Gilda Jones		Address 5929 LeMay Rd. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8224 Congestive Heart Failure DUE TO (b) Central Laceration & Contusion DUE TO (c) Trauma - Head Injury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile overturned	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2-5 1967 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) (County) (State) The Frederick-Fredrick-Md		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) ROBERT J. THOMAS, M.D.		22. DATE SIGNED 2-5-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-1967	
23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Gardens		23d. LOCATION (City or Town) (County) (State) Manassas, Virginia	
24. FUNERAL DIRECTOR Wailey's Funeral Home		ADDRESS Frederick Md.	
25a. REC'D BY REGISTRAR DATE FEB 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Office of the
Director

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Office of the Director, Division of Investigation, United States Department of Justice

Handwritten notes:
The following is a list of the names of the persons who have been assigned to the various divisions of the Bureau of Investigation, and who are now on duty at the Bureau.

Handwritten notes:
The following is a list of the names of the persons who have been assigned to the various divisions of the Bureau of Investigation, and who are now on duty at the Bureau.

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The following is a list of the names of the persons who have been assigned to the various divisions of the Bureau of Investigation, and who are now on duty at the Bureau.

Office of the Director, Division of Investigation, United States Department of Justice

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

(M)

02202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02198

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks		c. LENGTH OF STAY IN lb Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Point of Rocks, Maryland		d. STREET ADDRESS Point of Rocks	
3. NAME OF DECEASED (Type or print) EDYTHE GERALDINE KERRIGAN		4. DATE OF DEATH February 2 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1915
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours 10 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Sand Run, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Arthur Simmons		14. MOTHER'S MAIDEN NAME Laola Shipman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 234 05 8501	
17. INFORMANT Mr. Matthew R. Kerrigan		Address Same as item #21	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X Shock IMMEDIATE CAUSE (a) Shock DUE TO (b) Massive Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Gunshot Wound Chest		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot self in chest		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:00 2-2 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Point of Rocks - Frederick - Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) Robert J. Thomas, M. D.		22. DATE SIGNED 2-2-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Point of Rocks, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR Feb 6 1967	
25b. REGISTRAR'S SIGNATURE Donald M. Felleley		25c. REGISTRAR'S SIGNATURE Donald M. Felleley	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02203

CERTIFICATE OF DEATH

02199

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #2 Myersville		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE VIOLA McBRIDE		4. DATE OF DEATH Month Day Year February 21, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1882
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bidle		14. MOTHER'S MAIDEN NAME Julie Brane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. 215-50-4542	
17. INFORMANT Guy McBride, Myersville, Maryland.		18. ADDRESS Route # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Valvular Heart disease DUE TO (c) Arterio Sclerosis.		INTERVAL BETWEEN ONSET AND DEATH 27 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 20, 1967 , to Feb 21, 1967 , that (I) (we) saw the deceased alive on Feb 20, 1967 , and that death occurred at 4:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE J. Elmer Harp		22b. DATE SIGNED 2-21-67	
22c. PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp M.D.		22d. ADDRESS Middletown, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2/23/67	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	23d. LOCATION (City or Town) (County) (State) Middletown, Fred. Co. Md
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Maryland		25a. REC'D BY REGISTRAR FEB 24 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

02130

CERTIFICATE OF DEATH

00330

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

CAUSE OF MARRIAGE

DATE OF DEATH

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02204

CERTIFICATE OF DEATH

02200

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK c. LENGTH OF STAY IN TB MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONOCACY HALL NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) UNION BRIDGE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT LEE MILLER First Middle Last		4. DATE OF DEATH FEB. 17, 1967 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 19, 1876 9. AGE (In years last birthday) 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECTION FOREMAN RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN PETER MILLER		14. MOTHER'S MAIDEN NAME SUSAN HARBAUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MRS EDITH MOXLEY		Address UNION BRIDGE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis & metaplasia 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic CVD & mild myocardial failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 years 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-20-1966 to 2-17-1967 , that (I) (we) last saw the deceased alive on 2-16-1967 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James E. Stoner Jr		22b. DATE SIGNED 2/18/67	
22c. PHYSICIAN'S NAME (Type) JAMES E. STONER, JR		22d. ADDRESS WALKERSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	2-20-67	UNION CEMETERY	KEYSVILLE, MD
24. FUNERAL DIRECTOR'S SIGNATURE W. H. Harbaugh		25a. REC'D BY REGISTRAR FEB 21 1967	
ADDRESS UNION BRIDGE MD		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03200

CITIZENSHIP OF DEATH

03200

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CITIZENSHIP" and "DEATH" are visible.]

02205

CERTIFICATE OF DEATH

02201

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 East 'B' Street		d. STREET ADDRESS same	
3. NAME OF DECEASED (Type or print) WILLIAM FRANKLIN ODEN		4. DATE OF DEATH Month 2 Day 6 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/91
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired boiler maker		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Margaret Catherine Oden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705/10/2834	
17. INFORMANT Ruby Reed		Address Brunswick Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Anteauricular heart disease DUE TO (c) 10 yrs.			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-2-1967 , to 2-6-1967 , that (I) (we) saw the deceased alive on 2-6-1967 , and that death occurred at 10 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 2-9-67	
22c. PHYSICIAN'S NAME (Type) D. E. Pruitt		22d. ADDRESS Brunswick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/9/67	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	23d. LOCATION (City or Town) (County) (State) Point of Rocks Md.
24. FUNERAL DIRECTOR Frederick Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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RECEIVED IN BATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02202

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookville</i> 15.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS <i>Rt 1, Box 87</i>	
3. NAME OF DECEASED (Type or print) First <i>Warren</i> Middle <i>Cecil</i> Last <i>Pond</i>		4. DATE OF DEATH Month <i>February</i> Day <i>4</i> Year <i>19 67</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 26, 1905</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>19</i> Hours <i>67</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auditor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Internal Revenue Ser. Illinois</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Ollie Lane</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> <i>None</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>Claire Patenande</i>		Address <i>11320 Cherryhill Road Beltsville, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock & Congestive Heart Failure</i> DUE TO <i>Massive Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ruptured Aorta & Crushed Chest</i> (c) <i>Anteroseptal Heart Disease; Cerebral Arterioscl.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Two car head-on collision</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Two car head-on collision</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>105</i> p.m. <i>2-4</i> 19 <i>67</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>Libon - Howard - Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert J. Thomas</i> EXAMINER'S NAME (Type) <i>DR. R. J. THOMAS</i>		22. DATE SIGNED <i>4 Feb 67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb 7, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 9 1967</i>	
ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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02207

CERTIFICATE OF DEATH

02203

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville			c. LENGTH OF STAY IN lb 10Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Izora Middle Elizabeth Last Potter				4. DATE OF DEATH Month February Day 28 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1873		9. AGE (In years lost birthday) yrs. 93	IF UNDER 1 YEAR Months 5 Days 10 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Yarrowsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Hahn				14. MOTHER'S MAIDEN NAME Lydia Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Lena Gregg, Knoxville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO (b) Arteriosclerotic cardio-vascular disease DUE TO (c) 2 days							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 2-24-1967 to 2-28-1967 , that (I) (we) saw the deceased alive on 2-28-1967 , and that death occurred at 9:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE P. E. Pruitt				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-2-67	
22c. PHYSICIAN'S NAME (Type) P. E. Pruitt				22d. ADDRESS Brownsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-67		23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery		23d. LOCATION (City or Town) (County) (State) Brownsville, Md.	
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR MAR 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Antismoking cigarette program
Constitutive Board Review

3-5-51
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6. E. Smith
3-5-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02208

CERTIFICATE OF DEATH

02204

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		10.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Nursing Center		d. STREET ADDRESS Toll House Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle HAGAN Last PRICE		4. DATE OF DEATH Month February Day 5 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1891
9. AGE (In years) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. D. Hagan		14. MOTHER'S MAIDEN NAME Lydia Elizabeth Best	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-1631D	
17. INFORMANT Mr. Osborne I. Price, Jr.		Address Los Altos, Cal.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X MULTIPLE MYELOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6-8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CHRONIC PORPHRIA CUTANEA TARDEA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , to 2/5 , 19 67 that (I) (we) last saw the deceased alive on 2/4 , 19 67 , and that death occurred at 10:00 AM, from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 2-5-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds M.D.		22d. ADDRESS XXX 804 Toll House Ave. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR Frederick, Maryland	
25b. REGISTRAR'S SIGNATURE James Judge		DATE FEB 9 1967	

08280

STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02205

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> 101	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PARK MILLS ROAD</u>			d. STREET ADDRESS <u>PARK MILL ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>WILLIAM E RHINECKER</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>20</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 19-1902</u>		9. AGE (In years last birthday) yrs. <u>65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BY DAY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>JOHN T RHINECKER</u>		
14. MOTHER'S MAIDEN NAME <u>FLORENCE TUCKER</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			17. INFORMANT Address <u>MD</u> <u>CHARLES RHINECKER WESTMINSTER</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X</u> DUE TO (b) <u>Avulsion of Skull & Contents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head with Shotgun</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2</u> p.m. <u>20</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
		20f. (City or town) (County) (State) <u>Fredrick - Fredrick - Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Clifford B. Lull, Jr.</u>		M.D. <u>Clifford B. Lull, Jr.</u>		22. DATE SIGNED <u>2/22/67</u>	
EXAMINER'S NAME (Type) <u>Clifford B. Lull, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u></u>			
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>	
23d. LOCATION (City or Town) (County) (State) <u>UNIONTOWN MD</u>		24. FUNERAL DIRECTOR <u>W D Hartzler & Sons New Windsor</u>			
25a. REC'D BY REGISTRAR <u>FEB 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>W D Hartzler</u>			

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• To •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02210

CERTIFICATE OF DEATH

02206

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 1200 N. Market Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1200 North Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAMIE (MAY) Middle E. Last SCHILDKNECHT		4. DATE OF DEATH Month FEBRUARY Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1883
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months 1 Days 21 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Dept. Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josiah E. Schildknecht		14. MOTHER'S MAIDEN NAME Rebecca Hessong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3279	
17. INFORMANT Mrs. Harry C. Gilbert		Address Fred. 1200 N. Market St. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Semility DUE TO 194X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1952 , to 2-21-1967 , that (I) (we) last saw the deceased alive on 1965 , and that death occurred at 4 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Rex R. Martin		22b. DATE SIGNED 2-21-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin M.D.		22d. ADDRESS 220 N. Market Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-24-1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25. REC'D BY REGISTRAR FEB 27 1967	
25b. REGISTRAR'S SIGNATURE Robert E. Dailey & Son			

2155N

01520

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02207

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Germany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mainz, Germany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Johanna Lucie Elizabeth Schweizer		4. DATE OF DEATH Month Day Year February 7 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1908
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME Rudolf Kliesener		14. MOTHER'S MAIDEN NAME Martha Bach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Floyd Dennison, Fort Bragg, N. C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 4201 DUE TO (b) Coronary artery occlusion DUE TO (c) Arterio sclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Feb. 11, 1967	
23c. NAME OF CEMETERY Hillcrest Crematory		23d. LOCATION (City or Town) (County) (State) Cleveland, Ohio	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR FEB 10 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		22. DATE SIGNED 2/7/67	

02307

02311

Cleveland, Ohio

Historical Society

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02212											
02208											
1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE c. LENGTH OF STAY IN 1b YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE d. STREET ADDRESS RURAL e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARSHALL HENRY SHAFFER First Middle Last						4. DATE OF DEATH FEB 6 1967 Month Day Year					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 11 - 1901		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) QUARRY - PIT CEMENT CO.				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND				11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANKLIN SHAFFER						14. MOTHER'S MAIDEN NAME DELLA FARLEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 213-03-1012		17. INFORMANT MARY SHAFFER Address UNION BRIDGE MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Cerebral atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause test. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension Coronary atherosclerosis Gout INTERVAL BETWEEN ONSET AND DEATH about 1 week years.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 1963 Hour a.m. 2/5/67 p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1963 to 2/6/67 , that (I) (we) last saw the deceased alive on 2/5/67 , and that death occurred at 2:45 A.M. from the causes and on the date stated above. 22a. SIGNATURE DR JH CARICOFE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE 2/6/67 22c. PHYSICIAN'S NAME (Type) DR JH CARICOFE 22d. ADDRESS UNION BRIDGE MD 22b. DATE SIGNED											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/9/67		23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK				23d. LOCATION (City, town or county) (State) NEW WINDSOR RURAL MD			
24. FUNERAL DIRECTOR'S SIGNATURE W D Hartzler & Sons, Union Bridge Md						25a. REC'D BY REGISTRAR FEB 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

20556

51530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02213 CERTIFICATE OF DEATH 02209

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montevue Infirmary		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS Frederick, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA ELIZABETH SHAW		4. DATE OF DEATH Month February Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81 yrs.
11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel E. Shaw		14. MOTHER'S MAIDEN NAME Alice Null Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Katherine Shaw, 201 E. Second St.		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 16 days 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov , 19 63 , to Feb 11 , 19 67 , that (I) (we) last saw the deceased alive on Feb 11 , 19 67 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Le Roy T. Davis		22b. DATE SIGNED Feb. 11, 1967	
22c. PHYSICIAN'S NAME (Type) Le Roy T. Davis		22d. ADDRESS 228 N. Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR FEB 15 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02214					02210				
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick 21701 c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maryland Odd Fellows Home					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick 21701 d. STREET ADDRESS 326 East Patrick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last MAY GERTRUDE SHAW					4. DATE OF DEATH Month Day Year February 26, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 June 1885		9. AGE (In years last birthday) 81 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Bernard Thompson					14. MOTHER'S MAIDEN NAME Georgianna Phillips				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214 10 1138D		17. INFORMANT Maryland Odd Fellows Home (Same as item #1)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4221 DUE TO (b) Atherosclerotic C.V.D. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 16 mo 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jun 1, 1967 to Feb 26, 1967 , that (I) (we) last saw the deceased alive on Feb 25, 1967 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE Bernard O. Thomas Jr.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 27-1967		
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas-Jr.					22d. ADDRESS 228 N. Market St., Frederick, Md. 21701				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/1/67		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701		
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701					25a. REC'D BY REGISTRAR MAR 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02215					02211					
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
Frederick					Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Frederick					Frederick					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
Frederick Memorial Hospital					264 Dill Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last					Month Day Year					
Clarence Joseph Shriner					Feb 12 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		White		WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 17, 1892		74 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Ret. West. Md. R.R.				None		Frederick County, Md.		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Joseph Filmore Shriner					Laura May Eiler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No			705-12-2152		Mrs. Nettie M. Shriner			264 Dill Ave. Fred. Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Atherosclerotic Heart Disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>60</u> , to <u>Feb 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 12</u> 19 <u>67</u> , and that death occurred at <u>11P</u> M, from the causes and on the date stated above.										
22a. SIGNATURE								22b. DATE SIGNED		
<u>Henry V. Chase</u>								<u>12 Feb '67</u>		
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS		
<u>Henry V. Chase</u>								<u>804 Toll House Ave Frederick, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial			2-15-1967		Blue Ridge Cemetery		Thurmont, Maryland			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Robert E. Dailey & Son</u>					Frederick, Maryland		DATE		<u>FEB 17 1967</u>	
									<u>Charles Judge</u>	

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Charles J. Shinner

Ante preliminary advice
Attorney General / Ante Bureau

Dec 30 1961

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1961

Harvey V. Chase

Harvey V. Chase 804 Toll House Ave Frederick Md

CERTIFICATE OF DEATH

02216

02212

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
c. LENGTH OF STAY IN 1b 3 weeks		d. STREET ADDRESS 3 Meadow Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Augustus Skipper		4. DATE OF DEATH Feb 8 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Cutter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sarah (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-8784	
17. INFORMANT Raymond C. Skipper		Address Thurmont, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatous origin DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) site unknown DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1-2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis severe			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1967 , to Feb 8, 1967 , that (I) (we) lost saw the deceased alive on Feb 8, 1967 , and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 8 Feb 67	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 804 Toll House Ave Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-11-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick Fred. Co. Md.
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR Raymond E. Creager	
25b. REGISTRAR'S SIGNATURE Raymond E. Creager		25c. DATE FEB 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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OFFICE OF THE SECRETARY OF THE INTERIOR

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[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

02217

CERTIFICATE OF DEATH

02213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 235 E. Second St.				d. STREET ADDRESS 235 E. Second St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence Raymond Slack				4. DATE OF DEATH Month February Day 8 Year 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9- 1908		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY U. S. A.				13. FATHER'S NAME Frederick Slack				14. MOTHER'S MAIDEN NAME Carrie Lickey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-12-5876				17. INFORMANT Mrs. Eleanor M. Slack-235 E. 2nd St. - Frederick-Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE (c) 10 YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AORTIC STENOSIS				INTERVAL BETWEEN ONSET AND DEATH MINUTES				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from April 1960 to FEB. 1967 that (we) last saw the deceased alive on 1/3 1967 and that death occurred at 5:45p from the causes and on the date stated above.											
22a. SIGNATURE Richard C. Reynolds, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED Feb. 9-1967			
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds				22d. ADDRESS 804 Toll House Ave. - Frederick-Md. 21701							
23b. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23c. DATE THEREOF Feb. 11-1967				23d. NAME OF CEMETERY OR CREMATORY St. John's Catholic Cemetery Frederick, Md. 21701			
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son				25a. REC'D BY REGISTRAR Whitmore				25b. REGISTRAR'S SIGNATURE Frederick, Md. 21701			

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235 E. Second St.

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Nov. 9-1908

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Electrician

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Electrician

Frederick Jack

Frederick Jack

No

212-2-2870

212-2-2870 Mrs. Eleanor M. Black-235 E. Second St. - Frederick

Dr. Richard S. Reynolds

Dr. Richard S. Reynolds

Feb. 12-1907

Feb. 12-1907

Feb. 12-1907

M. A. Nicholson & Son

M. A. Nicholson & Son

M. A. Nicholson & Son

02218

CERTIFICATE OF DEATH

02214

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Frederick			
c. LENGTH OF STAY IN 1b 4 hours				d. STREET ADDRESS Route 7			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma Jane Summers				4. DATE OF DEATH Month Feb. Day 4 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15-1891	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75		IF UNDER 24 HRS. Hours 75 Min. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Rappahannock Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles French				14. MOTHER'S MAIDEN NAME Mary Susan Harris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-24-5692D		17. INFORMANT Address Mrs. Charles Putman- Route 3-Frederick, Md. 21701	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio-sclerotic C.V.D. (a), stating the underlying cause last. DUE TO (c) Diabetes							INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1967 to Feb. 4, 1967 , that (I) (we) last saw the deceased alive on Feb. 3, 1967 , and that death occurred at 12:05A from the causes and on the date stated above.							
22a. SIGNATURE B. O. Thomas Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 4-67	
22c. PHYSICIAN'S NAME (Type) Dr. B.O. Thomas, Jr.				22d. ADDRESS Professional Bldg.-Frederick, Md. 21701			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son				ADDRESS Elwood T. Whitmore		25a. REC'D BY REGISTRAR FEB 7 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00011

00011

Robert Schmitt C.I.

100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02219					02215				
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 22 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 50 Lincoln Apts e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carrie First Lucille Middle Thomas Last			4. DATE OF DEATH February 11 Month 1967 Day 11 Year						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 11, 1904		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Montgomery Co, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John T. Price				14. MOTHER'S MAIDEN NAME Mollie Washington					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *****		17. INFORMANT Miss Minnie Thomas		Address: Frederick, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Carcinomatosis DUE TO (c) Carcinoma of Cervix PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1964 , 19 present 19 present , that (I) (we) last saw the deceased alive on 2-11 19 67 , and that death occurred at 3A M, from the causes and on the date stated above.									
22a. SIGNATURE Rex R. Martin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-11-67			
22c. PHYSICIAN'S NAME (Type) Rex R. Martin				22d. ADDRESS 220 N. Market St, Frederick, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-67		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town or county) (State) Frederick Maryland			
24. FUNERAL DIRECTOR C.E. Hicks, 111				ADDRESS Frederick, Md		25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

62312

62312

Frederick	Frederick	Frederick	Frederick
28 yrs	28 yrs	28 yrs	28 yrs
Frederick Memorial Hospital	Frederick Memorial Hospital	Frederick Memorial Hospital	Frederick Memorial Hospital
60 Lincoln Ave	60 Lincoln Ave	60 Lincoln Ave	60 Lincoln Ave
February 11	February 11	February 11	February 11
Thomas	Thomas	Thomas	Thomas
Nov 11, 1904	Nov 11, 1904	Nov 11, 1904	Nov 11, 1904
Female Negro	Female Negro	Female Negro	Female Negro
X	X	X	X
Worcester, Mass	Worcester, Mass	Worcester, Mass	Worcester, Mass
U.S.A.	U.S.A.	U.S.A.	U.S.A.
John T. Polos	John T. Polos	John T. Polos	John T. Polos
Police	Police	Police	Police
212-24-2-05	212-24-2-05	212-24-2-05	212-24-2-05
Miss Minnie Thomas	Miss Minnie Thomas	Miss Minnie Thomas	Miss Minnie Thomas
47 Conn Person	47 Conn Person	47 Conn Person	47 Conn Person

Frederick	Frederick	Frederick	Frederick
2-14-07	2-14-07	2-14-07	2-14-07
Frederick	Frederick	Frederick	Frederick
230 N. Market St, Frederick, Md	230 N. Market St, Frederick, Md	230 N. Market St, Frederick, Md	230 N. Market St, Frederick, Md

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02216

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 South Bentz St			d. STREET ADDRESS 15 S. Bentz St		
3. NAME OF DECEASED (Type or print) Leroy NMN Timpson			4. DATE OF DEATH Month February Day 24 Year 19 67		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct 28, 1908		9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason	
11. BIRTHPLACE (State or foreign country) Frederick Co, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Timpson	
14. MOTHER'S MAIDEN NAME Rachel Price		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-05-4257	
17. INFORMANT George Timpson		Address Balto. Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Coronary Artery Occlusion DUE TO (c) Arteriosclerotic Cardiovascular Disease	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Alcoholism			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert J. Thomas		M.D.		22. DATE SIGNED 2/24/67	
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Frederick			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-26-67		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Church	
23d. LOCATION (City or Town) Della Frederick Md		23e. REC'D BY REGISTRAR DATE FEB 28 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR C.E. Hicks, 111		ADDRESS Frederick, Md			

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2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 26

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02221

CERTIFICATE OF DEATH

02217

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Knoxville</u> c. LENGTH OF STAY IN TOWN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Knoxville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>C.</u> Middle <u>Tucker</u> Last 4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1967</u>			5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6/5/1905</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman B&O R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY c. <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Howard Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Gross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Loudell Mazie Tucker Knoxville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Heart Disease</u> DUE TO (c) <u>Pulmonary Emphysema with Asthma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>4 yrs.</u> <u>9 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1</u>, 19<u>67</u>, to <u>Feb. 21</u>, 19<u>67</u> that (I) (we) last saw the deceased alive on <u>Feb. 21</u>, 19<u>67</u>, and that death occurred at <u>4 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>C. T. Byron Kao</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Feb. 22, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. T. Byron Kao, M.D.</u>				22d. ADDRESS <u>Gum Spring Hollow, Brunswick, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Knoxville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Knoxville Maryland</u>	
24. FUNERAL DIRECTOR <u>Leete Funeral Home</u>				25a. REC'D BY REGISTRAR <u>FEB 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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51350

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

02222

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02218

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 A. West Third Street		d. STREET ADDRESS 113 A. West Third Street	
3. NAME OF DECEASED (Type or print) BYRDIE M. WEAVER		4. DATE OF DEATH Month February Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1893
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marshall S. Grumbine		14. MOTHER'S MAIDEN NAME Cora Mae McAlister	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212 05 0812 D	
17. INFORMANT William H. Weaver, 521 Lee Place,		Address Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Arteriosclerotic & Hyper- stating the underlying cause last. (c) sensitive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) Robert J. Thomas, M. D.		22. DATE SIGNED 2-9-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 14 1967	

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CERTIFICATE OF DEATH

Reg. Dist. No. **02219****02223**

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp.				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Ellen Middle Blake Last White				4. DATE OF DEATH Month Feb. Day 15 Year 19 67			
5. SEX Female XXXXX		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26-1892	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Blake				14. MOTHER'S MAIDEN NAME Mary Hillary Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-44-6742		INFORMANT Malcolm White, Dickerson, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism 5615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Recent Bowel resection DUE TO (c) Strangulated Hernia Rt PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 31 Jan. 1967 to 15 Feb. 1967 that I last saw the deceased alive on 14 Feb. 1967 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Adel Demiray M.D. Fred McCauley PHYSICIAN'S NAME (Type) ADEL DEMIRAY Frederick Mayberry							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/67		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hutton				ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE FEB 20 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

032319

CERTIFICATE OF DEATH

032319

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Cause of Death		Place of Death	
Time of Death		Signature of Physician	
Signature of Registrar		Date of Registration	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Route 3355 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Frederick d. STREET ADDRESS Betsy Ross Trailer Court			
3. NAME OF DECEASED (Type or print) First HARVEY Middle C Last WILDER				4. DATE OF DEATH February 8, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1931	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman-Electrical Cont.		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Jonesville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude S. Wilder				14. MOTHER'S MAIDEN NAME Hazel Harvel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Betty Lou Wilder Address Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) Massive Hemorrhage DUE TO (c) Gunshot Wound of Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in left chest - .25 cal automatic					
20c. TIME OF INJURY 4:25 p.m. Month, Day, Year 2-8-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tavern		20f. (City or town) Frederick (County) Frederick (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert J. Thomas				22. DATE SIGNED 2-8-67			
EXAMINER'S NAME (Type) Robert J. Thomas				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-13-1967		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION (City, town or county) (State) Oxford, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son ADDRESS Frederick, Maryland				25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

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Director

CONFIDENTIAL

to order of the President

and the Vice President

TO :

FROM :

SUBJECT :

1. The President and Vice President have been advised that the following information is being furnished to you for your information.

2. The President and Vice President have been advised that the following information is being furnished to you for your information.

3. The President and Vice President have been advised that the following information is being furnished to you for your information.

4. The President and Vice President have been advised that the following information is being furnished to you for your information.

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13. The President and Vice President have been advised that the following information is being furnished to you for your information.

14. The President and Vice President have been advised that the following information is being furnished to you for your information.